tisements of the insurer's policies which were disseminated during the statement year complied or were made to comply in all respects with the provisions of the insurance laws of this state as implemented.

(30) PENALTY. Violations of this rule shall subject the violator to section 601.64, Wis. Stats.

(31) SEVERABILITY. The provisions of this rule are severable. If any provision of this rule is invalid, or if the application of the rule to any person or circumstance is invalid, such invalidity shall not affect other provisions or applications which can be given effect without the invalid provision or application.

(32) EFFECTIVE DATE. This rule shall apply to all advertisements used in this state after June 1, 1973.

History: Cr. Register, April, 1973, No. 208, eff. 6–1–73; am. (zb), (11) (c) 1. and (11) (e), Register, August, 1973, No. 212, eff. 9–1–73.

Ins 3.28 Solicitation, underwriting and claims practices in individual accident and sickness insurance. (1) PURPOSE. The purpose of this rule is to promote the fair and equitable treatment of Wisconsin residents in the solicitation, underwriting and administration of accident and sickness insurance and of contracts issued by a plan subject to section 200.26, Wis. Stats. Sections of Wis. Stats. interpreted or implemented by this rule include but are not limited to sections 201.045 (3), 601.01 (3) (b), 611.20, and 618.12 (1) Wis. Stats.

(2) SCOPE. This rule applies to the solicitation, underwriting and administration of any insurance issued by any insurer or fraternal benefit society under section 204.31, Wis. Stats., other than franchise insurance, and to any contract, other than one issued on a group or group type basis as defined in Wis. Adm. Code section Ins 6.51 (3), issued by a plan subject to section 200.26, Wis. Stats. For the purposes of this rule, the terms insurer, policy, and insurance agent or representative relate to organizations, contracts, and persons within the scope of this rule.

(3) APPLICATION FORM. An application form which becomes part of the insurance contract shall provide to the effect that statements made by the applicant in the application form regarding the general medical history or general health of a proposed insured person which require an opinion or the exercise of judgment are representations or are to the best of the applicant's knowledge and/or belief. Such form need not so provide with respect to statements regarding specifically named diseases, physical conditions, or types of medical consultation or treatment. Such form shall not require the applicant to state that he has not withheld any information or concealed any facts in completing the application; however, the applicant may be required to state that his answers are true and complete to the best of his knowledge and/or belief.

(4) SOLICITATION. An insurance agent or representative shall review carefully with the applicant all questions contained in each application which he prepares and shall set down in each such form all material information disclosed to him by the applicant in response to the questions in such form.

(5) UNDERWRITING. (a) An insurer shall make provision for adequate underwriting personnel and procedures so as to process without undue delay each application for insurance received by it.

(b) An insurer shall give due consideration to all statements in each application for insurance submitted to it and shall duly evaluate the proposed insured person before issuing coverage for such person.

(c) An insurer which issues coverage for a person without having resolved patently conflicting or incomplete statements in the application for the coverage, or fails to consider information furnished to it in connection with the processing of such application, or in connection with individual coverage on such person previously issued by it and currently in force, shall not use such statements or information to void the coverage or to deny a claim.

(d) An insurer shall, within 10 days after the issuance or amendment of a policy, contract or certificate, furnish to the policyholder, subscriber or certificate holder, where the application for the coverage or the amended coverage contains questions relating to the medical history or other matters concerning the insurability of the person or persons being insured and is part of the insurance contract, a notice, in the form of a sticker to be attached to the first page of the policy, a letter, or other form containing substantially the following:

IMPORTANT NOTICE
CONCERNING STATEMENTS IN THE APPLICATION
FOR YOUR INSURANCE

Please read the copy of the application attached to this notice or to your policy. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to the insurer within 10 days if any information shown on the application is not correct and complete or if any medical history has not been included. The application is part of the insurance contract. The insurance contract was issued on the basis that the answers to all questions and any other material information shown on the application are correct and complete.

(e) An insurer shall file with the Commissioner a description of the procedure it will follow and the form or forms it will use to meet the requirements of paragraph (d).

(f) An insurer which, after coverage for a person has been issued, receives information regarding such person which would reasonably be considered a sufficient basis to void or reform such person's coverage shall effect such voiding or reformation within a reasonable time, or the insurer shall be held to have waived its rights to such action.

(6) CLAIMS ADMINISTRATION. (a) If the existence of a disease or physical condition is duly disclosed in the application for coverage in response to the questions therein, the insurer shall not use the pre-existence defense, under coverage providing such a defense, to deny benefits for such disease or condition unless such disease or condition is excluded from coverage by name or specific description effective on the date of loss.

(b) If an application contains no question concerning the proposed insured person's health history or medical treatment history and regardless of whether it contains a question concerning the proposed insured person's general health at the time of the application, the insurer may use the pre-existence defense, under coverage pro-

viding such a defense, only with respect to losses incurred within twelve months from the effective date of coverage, unless the disease or physical condition causing the loss is excluded from coverage by name or specific description effective on the date of loss.

(c) An insurer shall not void coverage or deny a claim on the ground that the application for such coverage did not disclose certain information considered material to the risk if the application did not clearly require the disclosure of such information.

(d) A claim shall not be reduced or denied on the grounds that the disease or physical condition resulting in the loss had existed prior to the effective date of coverage, under coverage providing such a defense, unless the insurer has evidence that such disease or physical condition, as distinguished from the *cause* of such disease or physical condition, had manifested itself prior to such date. Such manifestation may be established by evidence of 1. medical diagnosis or treatment of such disease or physical condition prior to the effective date, or 2. the existence of symptoms of such disease or physical condition prior to the effective date which would cause an ordinarily prudent person to seek diagnosis, care, or treatment.

(e) Coverage which contains wording which requires the cause of the disease or physical condition, as distinguished from the disease or physical condition itself, to originate after the effective date of coverage shall be administered in accordance with paragraph (d) of this subsection.

(f) An insurer shall not exclude or limit benefits, using the preexistence defense, a waiting period, a benefit maximum or other policy limitation, where the claimant's medical records indicate a reasonable basis for distinguishing between the condition or conditions which necessitated the hospital confinement or the medical or surgical treatment for which claim is made or which resulted in the disability for which claim is made and a concurrently existing condition or conditions which did not contribute to the need for the confinement or treatment or did not contribute to the disability.

(7) EFFECTIVE DATE. (a) Subsections (4), (5) (a), (b), (c), and (e) and (6) shall apply to all solicitation, underwriting, and claims activities relating to Wisconsin residents after March 1, 1974.

(b) Subsections (3) and (5) (d) and (e) shall apply to all solicitation, underwriting and claims activities relating to Wisconsin residents after May 1, 1974.

History: Cr. Register, February, 1974, No. 218, eff. 3–1–74; am. (5) (d) (intro. par.), Register, July, 1974, No. 223, eff. 8–1–74.

Ins 3.29 Replacement of accident and sickness insurance. (1) PURPOSE. The purpose of this rule is to safeguard the interests of persons covered under accident and sickness insurance who consider the replacement of their insurance by making available to them information regarding replacement and thereby reducing the opportunity for misrepresentation and other unfair practices and methods of competition in the business of insurance. This rule implements and interprets sections 201.53 (13), 207.04 (1) (a), and 601.01 (3) (b), Wis. Stats.

(2) SCOPE. This rule shall apply to the solicitation of accident and sickness insurance covering residents of this state and issued by insurance corporations, fraternal benefit societies or nonprofit service

plans in accordance with sections 201.04 (4), 208.01 or 200.26, Wis. Stats.

(3) EXEMPT INSURANCE. This rule shall not apply to the solicitation of the following accident and sickness insurance:

(a) Group, blanket or group type,

(b) Accident only,

(c) Single premium nonrenewable,

(d) Nonprofit dental care,

(e) Nonprofit prepaid optometric service,

(f) A limited policy conforming to Wisconsin Administrative Code section Ins 3.13 (2) (h),

(g) Under which dental expenses only, prescription expenses only, vision care expenses only or blood service expenses only are covered,

(h) Conversion to another individual or family policy in the same insurer with continuous coverage,

(i) Conversion to an individual or family policy to replace group, blanket or group type coverage in the same insurer,

(j) Change to a Medicare supplement policy which covers preexisting conditions, without any limitation, to replace a basic hospital expense, basic medical expense, basic surgical expense, or major-medical expense policy.

(4) DEFINITIONS. For the purposes of this rule:

(a) *Replacement* is any transaction wherein new accident and sickness insurance is to be purchased, and it is known to the agent or company at the time of application that as part of the transaction, existing accident and sickness insurance has been or is to be lapsed or the benefits thereof substantially reduced.

(b) *Continuous coverage* means that the benefits are not less than the benefits under the previous policy, and the policy also covers loss resulting from injury sustained or sickness contracted while coverage was in force under the previous policy to the extent such loss is not covered under any extended benefit or similar provision of the previous policy.

(c) *Group type coverage* is as defined in Wis. Adm. Code section Ins 6.51 (3).

(d) *Direct response insurance* is insurance issued to an applicant who has himself completed the application and forwarded it directly to the insurer in response to a solicitation coming into his possession by any means of mass communication.

(5) REPLACEMENT QUESTION IN APPLICATION FORMS. An application form for insurance subject to this rule shall contain a question to elicit information as to whether the insurance to be issued is to replace any insurance presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.

(6) NOTICE TO BE FURNISHED. (a) An agent soliciting the sale of insurance shall, upon determining that the sale would involve replacement, furnish to the applicant, at the time of taking the application, the notice described in subsection (7) to be signed by the applicant.